DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/08/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	FIPLE CONSTRUCTION NG 01, 02, 03			(X3) DATE SURVEY COMPLETED	
155448					1	R		
NAME OF D		155448	B. WING	OTE	RET ADDRESS SITV STATE ZID SODE	07	//06/2016	
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
LOWELL	HEALTHCARE				MICHIGAN ST			
				LO	WELL, IN 46356			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
{K 000}	INITIAL COMMENTS		{K ((000				
	Code Recertification conducted on 06/01/1 Indiana State Departs accordance with 42 C Survey Date: 07/06/1 Facility Number: 0003 Provider Number: 153 AIM Number: 100266 At this PSR survey, L was found in complia Participation in Medic Subpart 483.70(a), Li 2000 edition of the Na Association (NFPA) 1 Chapter 19, Existing and 410 IAC 16.2. This facility was built a partial basement will and connected to the stairway prior to Marc refers to the levels as fourth floors. The corbe of Type II (111) co sprinklered. The face	CFR 483.70(a). 6 361 5448 3340 cowell Healthcare Center nee with Requirements for care/Medicaid, 42 CFR fe Safety from Fire and the ational Fire Protection 01, Life Safety Code (LSC), Health Care Occupancies as a two story building over the atwo story addition offset original structure by a ch 1, 2003. The facility the first, second, third and instruction was determined to instruction and was fully illity has a fire alarm system e detection in the corridors						
	provided with battery The facility has the ca census of 76 at the til	powered smoke detector. apacity for 86 and had a me of this survey. o residents and all areas						
I ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR)E		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03		(X3) DATE SURVEY COMPLETED		
		155448	B. WING		R 07/06/2016		
NAME OF DE	ROVIDER OR SUPPLIER	1007-10			STREET ADDRESS, CITY, STATE, ZIP CODE	077	06/2016
TVAME OF T	TOVIDER OR OUT FEILER				710 MICHIGAN ST		
LOWELL HEALTHCARE				LOWELL, IN 46356			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{K 000}	Continued From page	÷1	{K 0	000	}		
	A Post Survey Revisi Code Recertification a conducted on 06/01/1 Indiana State Departr accordance with 42 C Survey Date: 07/06/10 Facility Number: 0003 Provider Number: 158 AIM Number: 100266 At this PSR survey, L was found in complian Participation in Medic Subpart 483.70(a), Lit 2000 edition of the Na Association (NFPA) 1 Chapter 19, Existing I and 410 IAC 16.2. This facility was built a partial basement wi and connected to the	FR 483.70(a). 6 361 5448 340 owell Healthcare Center nce with Requirements for are/Medicaid, 42 CFR fe Safety from Fire and the					
	refers to the levels as fourth floors. The corbe of Type II (111) corsprinklered. The faci with hard wired smokand common areas. provided with battery	the first, second, third and instruction was determined to instruction and was fully lility has a fire alarm system e detection in the corridors Resident rooms are powered smoke detector.					
	All areas accessible to providing facility servi	o residents and all areas ces are sprinklered.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03			(X3) DATE SURVEY COMPLETED	
						ı	₹
		155448	B. WING			07/	06/2016
	ROVIDER OR SUPPLIER			7	STREET ADDRESS, CITY, STATE, ZIP CODE 10 MICHIGAN ST .OWELL, IN 46356		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	Continued From page	2	{K 0	00}			
{K 000}	Quality Review compl INITIAL COMMENTS	leted on 07/07/16 - DA	{K 0	00}			
	Code Recertification a						
	Survey Date: 07/06/10	6					
	Facility Number: 0003 Provider Number: 155 AIM Number: 100266	5448					
	was found in complian Participation in Medic Subpart 483.70(a), Lit 2000 edition of the Na Association (NFPA) 1 Chapter 19, Existing I and 410 IAC 16.2. The main dining room 18, New Health Care Code (LSC), and 410 addition of 14 rooms of	01, Life Safety Code (LSC), Health Care Occupancies ne 2012 one story addition to was surveyed with Chapter Facilities. 101, Life Safety					
	a partial basement wir and connected to the stairway prior to Marc refers to the levels as fourth floors. The cor be of Type II (111) cor	as a two story building over th a two story addition offset original structure by a th 1, 2003. The facility the first, second, third and astruction was determined to astruction and was fully lity has a fire alarm system					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG 01, 02, 03	(X3	(X3) DATE SURVEY COMPLETED		
		155448	B. WING			R 07/06/2016		
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIF 710 MICHIGAN ST LOWELL, IN 46356	CODE	07/06/2016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
{K 000}	with hard wired smol and common areas. provided with battery The facility has the c census of 76 at the ti All areas accessible providing facility serv	Re detection in the corridors Resident rooms are r powered smoke detector. apacity for 86 and had a ime of this survey. to residents and all areas	{K 0	000}				